Vocational Services-Buffalo Psychiatric Center
Enrollment: NYS OMH Academy of Peer Service Classroom Training (APS)

Please PRINT
Name_____ Date _____

Address _____ City/Town _____ Zip _____

Contact Phone# _____
Emergency Contact# _____ Relationship _____

Email address: _____

Reason you are attending these training modules-*please check **ALL** that apply*

_____ To gain own personal knowledge/growth
_____ To challenge my ability to learn
_____ To become or be a better peer leader and mentor
_____ To volunteer as a peer leader
_____ To become a Certified Peer Specialist
_____ My career goal is to work as a Peer Specialist
_____ I've completed the APS modules but would like to review and gain more knowledge
_____ I started the APS modules but see the benefit of learning within a classroom environment
_____ OTHER: Please describe _____

Have you completed and passed any APS modules prior to enrolling with us? YES NO
If NO---go to next question
If YES: Which modules? _____
_____
If YES: What, if anything, did you find most challenging about APS modules? _____
_____

APS class will be offered Tues & Wed from 1-4pm *(unless otherwise indicated on schedule)*
Are you able to attend both classes? YES NO

Please answer the following:

YES	NO	
		Will you need help setting up your on-line APS account?
		Do you know how to log in/out on a website?
		Do you frequently use the internet? *shopping, social media, email, bus schedule, pay bills, google search*
		Do you have computer access from home?
		Do you have an email account that you check frequently?
		Do you have a GMAIL account?
		Are you skilled enough to help someone else use the computer?
		Have you ever taken an on-line course before?
		Have you ever taken an on-line test or completed an application on-line before?

DO YOU RECEIVE ANY SERVICES FROM BUFFALO PSYCHIATRIC CENTER? Yes or **No**

OUTPATIENT CLINIC_____ (NAME WHICH ONE)
RESIDENTIAL_____ (NAME WHICH ONE)
VOCATIONAL_____ (NAME from who)
ACT or MOBILE CRISIS TEAM_____
ELMWOOD WELLNESS CENTER MEMBER_____ GOALS CENTER_____
IF NOT, WHERE DO YOU RECEIVE SERVICES FOR MENTAL HEALTH? _____
Address _____

Are you currently working? _____ If yes, how many hrs/wk? _____ Position _____
Where _____

Are you currently enrolled in ACCES-VR YES [ ] NO [ ]
Were you ever enrolled in ACCES-VR(VESID) YES [ ] NO [ ]
If so what year_____
Have you ever assigned your ***'Ticket to Work'*** YES [ ] NO [ ]
If yes, what agency_____ What year?_____
When is the last time you have received services from this agency_____
Are you actively receiving vocational services? _____ If yes, where? _____
_____
Do you have a NYS Career Zone or Job Zone account? YES [ ] NO [ ]

I attest the information above and within this enrollment form, is truthful, to the best of my ability. I would like to join the classroom group to take part in the Academy of Peer Services-APS training modules offered on Tuesdays and Wednesdays, from 1-4pm in the Discovery Ctr/Butler Bldg of Buffalo PC. I consent to contacting me, if the need arises, to inform me about any schedule changes of the APS training modules offered, or other valid and pertinent information.

_____ _____
Signature of Enrollee *DATE*

If further questions; CONTACT: Robin Alwine 716-816-2494 or email: robin.alwine@omh.ny.gov
Return form: FAX: 716-816-2905 or Robin Alwine Buffalo PC, 400 Forest Ave; Buffalo, NY 14213

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Office Use Only:

Date contacted _____ initials _____

Person is _____accepted Start date: _____

_____ not accepted Provide brief reason why, if applicable:
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